

COMMITTEE REPORT

MADAM PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1572, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

- 1 Page 1, between the enacting clause and line 1, begin a new
- 2 paragraph and insert:
- 3 "SECTION 1. IC 2-5-23-4 IS AMENDED TO READ AS
- 4 FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 4. **(a)** The commission
- 5 may study any topic:
- 6 (1) directed by the chairman of the commission;
- 7 (2) assigned by the legislative council; or
- 8 (3) concerning issues that include:
- 9 (A) the delivery, payment, and organization of health care
- 10 services;
- 11 (B) rules adopted under IC 4-22-2 that pertain to health care
- 12 delivery, payment, and services that are under the authority of
- 13 any board or agency of state government; and
- 14 (C) the implementation of IC 12-10-11.5.
- 15 **(b) The commission shall study all aspects of the health facility**
- 16 **quality assessment fee collected by the office of Medicaid policy**
- 17 **and planning."**
- 18 Page 2, line 27, delete "quarterly" and insert "**an annual report not**
- 19 **later than September 15 of each year"**.
- 20 Page 2, line 28, delete "reports".

1 Page 2, line 28, delete "and the select joint commission on".

2 Page 2, line 29, delete "Medicaid oversight".

3 Page 2, line 29, delete "summarize" and insert **"summarizes"**.

4 Page 2, delete lines 33 through 42, begin a new paragraph and
5 insert:

6 "SECTION 3. IC 12-13-5-14 IS ADDED TO THE INDIANA CODE
7 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
8 1, 2009]: **Sec. 14. (a) As used in this section, "commission" refers**
9 **to the select joint commission on Medicaid oversight (IC 2-5-26-3).**

10 **(b) A contractor for the division, office, or secretary that has**
11 **responsibility for processing eligibility intake for the federal**
12 **Supplemental Nutrition Assistance program (SNAP), the**
13 **Temporary Assistance for Needy Families (TANF) program, and**
14 **the Medicaid program shall do the following:**

15 **(1) Review the eligibility intake process for:**

16 **(A) document management issues, including:**

- 17 **(i) unattached documents;**
- 18 **(ii) number of documents received by facsimile;**
- 19 **(iii) number of documents received by mail;**
- 20 **(iv) number of documents incorrectly classified;**
- 21 **(v) number of documents that are not indexed or not**
22 **correctly attached to cases;**
- 23 **(vi) number of complaints from clients regarding lost**
24 **documents; and**
- 25 **(vii) number of complaints from clients resolved**
26 **regarding lost documents;**

27 **(B) direct client assistance at county offices, including the:**

- 28 **(i) number of clients helped directly in completing**
29 **eligibility application forms;**
- 30 **(ii) wait times at local offices;**
- 31 **(iii) amount of time an applicant is given as notice before**
32 **a scheduled applicant appointment;**
- 33 **(iv) amount of time an applicant waits for a scheduled**
34 **appointment; and**
- 35 **(v) timeliness of the tasks sent by the contractor to the**
36 **state for further action, as specified through contracted**
37 **performance standards; and**

38 **(C) call wait times and abandonment rates.**

(2) Provide an update on employee training programs.

(3) Provide a copy of the monthly key performance indicator report.

(4) Provide information on error reports and contractor compliance with the contract.

(5) Provide oral and written reports to the commission concerning matters described in subdivision (1):

(A) in a manner and format to be agreed upon with the commission; and

(B) whenever the commission requests.

(c) Solely referring an individual to a computer or telephone does not constitute the direct client assistance referred to in subsection (b)(1)(B).

SECTION 4. IC 23-2-4-1, AS AMENDED BY P.L.27-2007, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means **the following:**

(1) For continuing care retirement communities registered before July 1, 2009, an agreement by a provider to furnish to ~~at least one (1)~~ **an** individual, for the payment of an entrance fee of **at least twenty-five thousand dollars (\$25,000)** and periodic charges:

(A) accommodations in a living unit of a ~~home and~~ continuing care retirement community;

~~(1)~~ **(B) meals and related services;**

~~(2)~~ **(C) nursing care services;**

~~(3)~~ **(D) medical services;**

~~(4)~~ **(E) other health related services; or**

~~(5)~~ **(F) any combination of these services;**

for the life of the individual or for more than one (1) month, unless the agreement is cancelled.

(2) For continuing care retirement communities registered

1 after June 30, 2009, an agreement by a provider to furnish to
 2 an individual, for the payment of an entrance fee of at least
 3 twenty-five thousand dollars (\$25,000) and periodic charges:

4 (A) accommodations in a living unit of a continuing care
 5 retirement community;

6 (B) meals and related services;

7 (C) nursing care services;

8 (D) medical services;

9 (E) other health related services; or

10 (F) any combination of these services;

11 for the life of the individual, unless the agreement is
 12 terminated as specified under this chapter.

13 "Continuing care retirement community" includes both of the
 14 following:

15 (1) An independent living facility.

16 (2) A health facility licensed under IC 16-28.

17 "Contracting party" means a person or persons who enter into a
 18 continuing care agreement with a provider.

19 "Entrance fee" means the sum of money or other property paid or
 20 transferred, or promised to be paid or transferred, to a provider in
 21 consideration for one (1) or more individuals becoming a resident of a
 22 ~~home continuing care retirement community~~ under a continuing care
 23 agreement.

24 "Home" means a facility where the provider undertakes, pursuant to
 25 a continuing care agreement, to provide continuing care to five (5) or
 26 more residents.

27 "Living unit" means a room, apartment, cottage, or other area within
 28 a ~~home continuing care retirement community~~ set aside for the use
 29 of one (1) or more identified residents.

30 "Long term financing" means financing for a period in excess of one
 31 (1) year.

32 "Omission of a material fact" means the failure to state a material
 33 fact required to be stated in any disclosure statement or registration in
 34 order to make the disclosure statement or registration, in light of the
 35 circumstances under which they were made, not misleading.

36 "Person" means an individual, a corporation, a partnership, an
 37 association, a limited liability company, or other legal entity.

38 "Provider" means a person that agrees to provide ~~continuing care to~~

1 ~~an individual~~ under a continuing care agreement.

2 "Refurbishment fee" means the fee charged an individual, in
3 addition to the entrance fee or any other fee, to cover the provider's
4 reasonable costs in refurbishing a previously occupied living unit
5 specifically designated for occupancy by that individual.

6 "Resident" means an individual who is entitled to receive benefits
7 under a continuing care agreement.

8 "Solicit" means any action of a provider in seeking to have an
9 individual residing in Indiana pay an application fee and enter into a
10 continuing care agreement, including:

11 (1) personal, telephone, or mail communication or any other
12 communication directed to and received by any individual in
13 Indiana; and

14 (2) advertising in any media distributed or communicated by any
15 means to individuals residing in Indiana.

16 **"Termination" refers to the cancellation of a continuing care**
17 **agreement under this chapter.**

18 SECTION 5. IC 23-2-4-2 IS AMENDED TO READ AS FOLLOWS
19 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 2. This
20 chapter applies to any person who:

21 (1) enters into a continuing care agreement in Indiana to provide
22 care at a ~~home~~ **continuing care retirement community** located
23 either inside Indiana or outside Indiana;

24 (2) enters into a continuing care agreement outside Indiana to
25 provide care at a ~~home~~ **continuing care retirement community**
26 located in Indiana;

27 (3) extends the term of an existing continuing care agreement in
28 Indiana to provide care at a ~~home~~ **continuing care retirement**
29 **community** located either inside Indiana or outside Indiana;

30 (4) extends the term of an existing continuing care agreement
31 outside Indiana to provide care at a ~~home~~ **continuing care**
32 **retirement community** located in Indiana; or

33 (5) solicits the execution of a continuing care agreement by
34 persons in Indiana.

35 SECTION 6. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS
36 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A
37 provider shall register each ~~home~~ **continuing care retirement**
38 **community** with the commissioner if:

1 **(1) before opening the continuing care retirement community,**
 2 **the provider:**

3 **(A) enters into;**

4 **(B) extends; or**

5 **(C) solicits;**

6 **a continuing care agreement; or**

7 **(2) while operating the continuing care retirement**
 8 **community, the provider has entered into a continuing care**
 9 **agreement with at least twenty-five percent (25%) of the**
 10 **individuals living in the continuing care retirement**
 11 **community.**

12 **(b) If a provider fails to register a ~~home~~, continuing care**
 13 **retirement community, the provider may not:**

14 (1) enter into, or extend the term of, a continuing care agreement
 15 to provide continuing care to any person at that ~~home~~, **continuing**
 16 **care retirement community;**

17 (2) provide services at that ~~home~~ **continuing care retirement**
 18 **community** under a continuing care agreement; or

19 (3) solicit the execution, by persons residing within Indiana, of a
 20 continuing care agreement to provide continuing care at that
 21 ~~home~~, **continuing care retirement community.**

22 ~~(b)~~ **(c)** The provider's application for registration must be filed with
 23 the commissioner by the provider on forms prescribed by the
 24 commissioner, and must be accompanied by an application fee of two
 25 hundred fifty dollars (\$250). The application must contain the
 26 following information:

27 (1) an initial disclosure statement, as described in section 4 of this
 28 chapter; and

29 (2) any other information required by the commissioner under
 30 rules adopted under this chapter.

31 ~~(c)~~ **(d)** The commissioner may accept, in lieu of the information
 32 required by subsection ~~(b)~~, **(c)**, any other registration, disclosure
 33 statement, or other document filed by the provider in Indiana, in any
 34 other state, or with the federal government if the commissioner
 35 determines that such document substantially complies with the
 36 requirements of this chapter.

37 ~~(d)~~ **(e)** Upon receipt of the application for registration, the
 38 commissioner shall mark the application filed. Within sixty (60) days

of the filing of the application, the commissioner shall enter an order registering the provider or rejecting the registration. If no order of rejection is entered within that sixty (60) day period, the provider shall be considered registered unless the provider has consented in writing to an extension of time; if no order of rejection is entered within the time period as extended by consent, the provider shall be considered registered.

~~(e)~~ **(f)** If the commissioner determines that the application for registration complies with all of the requirements of this chapter, the commissioner shall enter an order registering the provider. If the commissioner determines that such requirements have not been met, the commissioner shall notify the provider of the deficiencies and shall inform the provider that it has sixty (60) days to correct them. If the deficiencies are not corrected within sixty (60) days, the commissioner shall enter an order rejecting the registration. The order rejecting the registration shall include the findings of fact upon which the order is based. The provider may petition for reconsideration, and is entitled to a hearing upon that petition.

SECTION 7. IC 23-2-4-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 4. The initial disclosure statement shall contain the following information:

- (1) The name and business address of the provider.
- (2) If the provider is a partnership, corporation, limited liability company, or association, the names and duties of its officers, directors, trustees, partners, members, or managers.
- (3) The name and business address of any person having a five percent (5%) or greater ownership interest in the provider or manager of the ~~home~~: **continuing care retirement community**.
- (4) A description of the business experience of the provider and its officers, directors, trustees, partners, or managers.
- (5) A statement as to whether the provider or any of its officers, directors, trustees, partners, or managers, within ten (10) years prior to the date of the initial disclosure statement:
 - (A) was convicted of a crime;
 - (B) was a party to any civil action for fraud, embezzlement, fraudulent conversion, or misappropriation of property that resulted in a judgment against ~~him~~; **the provider or individual**;

- 1 (C) had a prior discharge in bankruptcy or was found insolvent
- 2 in any court action; or
- 3 (D) had any state or federal licenses or permits suspended or
- 4 revoked in connection with any health care or continuing care
- 5 activities, or related business activities.
- 6 (6) The identity of any other ~~home~~ **continuing care retirement**
- 7 **community** currently or previously operated by the provider or
- 8 manager of the ~~home~~; **continuing care retirement community**.
- 9 (7) The location and description of other properties, both existing
- 10 and proposed, of the provider in which the provider owns a
- 11 twenty-five percent (25%) ownership interest, and on which
- 12 ~~homes~~ **continuing care retirement communities** are or are
- 13 intended to be located.
- 14 (8) A statement as to whether the provider is, or is affiliated with,
- 15 a religious, charitable, or other nonprofit association, and the
- 16 extent to which the affiliate organization is responsible for the
- 17 financial and contractual obligations of the provider.
- 18 (9) A description of all services to be provided by the provider
- 19 under its continuing care agreements with contracting parties, and
- 20 a description of all fees for those services, including conditions
- 21 under which the fees may be adjusted.
- 22 (10) A description of the terms and conditions under which the
- 23 continuing care agreement can be cancelled, or fees refunded.
- 24 (11) Financial statements of the provider prepared in accordance
- 25 with generally accepted accounting principles applied on a
- 26 consistent basis and certified by an independent certified or
- 27 public accountant, including a balance sheet as of the end of the
- 28 provider's last fiscal year and income statements for the last three
- 29 (3) fiscal years, or such shorter period of time as the provider has
- 30 been in operation.
- 31 (12) If the operation of the ~~home~~ **continuing care retirement**
- 32 **community** has not begun, a statement of the anticipated source
- 33 and application of funds to be used in the purchase or
- 34 construction of the ~~home~~; **continuing care retirement**
- 35 **community**, and an estimate of the funds, if any, which are
- 36 anticipated to be necessary to pay for start-up losses.
- 37 (13) A copy of the forms of agreement for continuing care used by
- 38 the provider.

(14) Any other information that the commissioner may require by rule or order.

SECTION 8. IC 23-2-4-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 5. (a) Each year after the initial year in which a ~~home~~ **continuing care retirement community** is registered under section 3 of this chapter, the provider shall file with the commissioner within four (4) months after the end of the provider's fiscal year, unless otherwise extended by the written consent of the commissioner, an annual disclosure statement which shall consist of the financial information set forth in section 4(11) of this chapter.

(b) The annual disclosure statement required to be filed with the commissioner under this section shall be accompanied by an annual filing fee of one hundred dollars (\$100).

SECTION 9. IC 23-2-4-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 6. (a) A provider shall amend its initial or annual disclosure statement filed with the commissioner under section 3 and section 5 of this chapter at any time if necessary to prevent the initial or annual disclosure statement from containing any material misstatement of fact or omission of a material fact.

(b) Upon the sale of a ~~home~~ **continuing care retirement community** to a new provider, the new provider shall amend the currently filed disclosure statement to reflect the fact of sale and any other fact that would be required to be disclosed under section 4 of this chapter if the new provider were filing an initial disclosure statement.

SECTION 10. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 7.5. (a) **This section does not apply to a continuing care retirement community registered before July 1, 2009.**

(b) **A continuing care agreement may be terminated for any of the following reasons:**

(1) **The provider has determined that the resident is inappropriate for living in the care setting.**

(2) **The resident is unable to fully pay the periodic charges because the resident inappropriately divested the assets and income the resident identified at the time of admission to meet**

1 **the ordinary and customary living expenses for the resident.**

2 **(3) Providing assistance to the resident would jeopardize the**
 3 **financial solvency of the provider and the other residents**
 4 **being served by the provider.**

5 **(4) The resident has requested a termination of the agreement**
 6 **as allowed under the agreement.**

7 SECTION 11. IC 23-2-4-10 IS AMENDED TO READ AS
 8 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:

9 Sec. 10. (a) Except as provided by section 11 of this chapter, the
 10 commissioner shall require, as a condition of registration, that:

11 (1) the provider establish an interest-bearing escrow account with
 12 a bank, trust company, or other escrow agent approved by the
 13 commissioner; and

14 (2) any entrance fees received by the provider prior to the date the
 15 resident is permitted to occupy the living unit in the ~~home~~
 16 **continuing care retirement community** be placed in the escrow
 17 account, subject to release as provided by subsection (b).

18 (b) If the entrance fee gives the resident the right to occupy a living
 19 unit that has been previously occupied, the entrance fee and any
 20 income earned thereon shall be released to the provider when the living
 21 unit is first occupied by the new resident. If the entrance fee applies to
 22 a living unit that has not been previously occupied by any resident, the
 23 entrance fee and any income earned thereon shall be released to the
 24 provider when the commissioner is satisfied that:

25 (1) aggregate entrance fees received or receivable by the provider
 26 pursuant to executed continuing care agreements, plus:

27 (A) anticipated proceeds of any first mortgage loan or other
 28 long term financing commitment; and

29 (B) funds from other sources in the actual possession of the
 30 provider;

31 are equal to at least fifty percent (50%) of the aggregate cost of
 32 constructing, purchasing, equipping, and furnishing the ~~home~~
 33 **continuing care retirement community** and equal to at least
 34 fifty percent (50%) of the estimate of funds necessary to fund
 35 startup losses of the ~~home~~; **continuing care retirement**
 36 **community**, as reported under section 4(12) of this chapter; and

37 (2) a commitment has been received by the provider for any
 38 permanent mortgage loan or other long term financing described

1 in the statement of anticipated source and application of funds to
 2 be used in the purchase or construction of the ~~home~~ **continuing**
 3 **care retirement community** under section 4(12) of this chapter,
 4 and any conditions of the commitment prior to disbursement of
 5 funds thereunder, other than completion of the construction or
 6 closing of the purchase of the ~~home~~; **continuing care retirement**
 7 **community**, have been substantially satisfied.

8 (c) If the funds in an escrow account under this section and any
 9 interest earned thereon are not released within the time provided by this
 10 section or by rules adopted by the commissioner, then the funds shall
 11 be returned by the escrow agent to the persons who made the payment
 12 to the provider.

13 (d) An entrance fee held in escrow shall be returned by the escrow
 14 agent to the person who paid the fee in the following instances:

15 (1) At the election of the person who paid the fee, at any time
 16 before the fee is released to the provider under subsection (b).

17 (2) Upon receipt by the escrow agent of notice from the provider
 18 that the person is entitled to a refund of the entrance fee.

19 (e) This section does not require a provider to place a nonrefundable
 20 application fee charged to prospective residents in escrow.

21 (f) A provider is not required to place a refurbishment fee of a
 22 prospective resident in escrow if a continuing care agreement provides
 23 that the prospective resident:

24 (1) will occupy the living unit within sixty (60) days after the
 25 refurbishment fee is paid; and

26 (2) will receive a refund of any portion of the refurbishment fee
 27 not expended for refurbishment if the continuing care agreement
 28 is cancelled before occupancy.

29 SECTION 12. IC 23-2-4-12 IS AMENDED TO READ AS
 30 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:

31 Sec. 12. Any money or property received by a provider as an entrance
 32 fee to a ~~home~~ **continuing care retirement community** constructed or
 33 purchased after August 31, 1982, or any income earned thereon, may
 34 be used by the provider only for purposes directly related to the
 35 construction, maintenance, or operation of that particular ~~home~~;
 36 **continuing care retirement community**. A ~~home~~ **continuing care**
 37 **retirement community** in operation on September 1, 1982, may not
 38 use the entrance fees or income earned thereon after August 31, 1982,

1 for the construction, operation, or maintenance of another ~~home~~
 2 **continuing care retirement community** constructed or purchased
 3 after August 31, 1982.

4 SECTION 13. IC 23-2-4-13, AS AMENDED BY P.L.2-2006,
 5 SECTION 180, IS AMENDED TO READ AS FOLLOWS
 6 [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the
 7 Indiana retirement home guaranty fund. The purpose of the fund is to
 8 provide a mechanism for protecting the financial interests of residents
 9 and contracting parties in the event of the bankruptcy of the provider.

10 (b) To create the fund, a guaranty association fund fee of one
 11 hundred dollars (\$100) shall be levied on each contracting party who
 12 enters into a continuing care agreement after August 31, 1982, **and**
 13 **before July 1, 2009**. The fee shall be collected by the provider and
 14 forwarded to the commissioner within thirty (30) days after occupancy
 15 by the resident. Failure of the provider to collect and forward such fee
 16 to the commissioner within that thirty (30) day period shall result in the
 17 imposition by the commissioner of a twenty-five dollar (\$25) penalty
 18 against the provider. In addition, interest payable by the provider shall
 19 accrue on the unpaid fee at the rate of two percent (2%) a month.

20 (c) Any money received by the commissioner under subsection (b)
 21 shall be forwarded to the treasurer of state. The fund, and any income
 22 from it, shall be held in trust, deposited in a segregated account,
 23 invested and reinvested by the treasurer of state in the same manner as
 24 provided in IC 20-49-3-10 for investment of the common school fund.

25 (d) All reasonable expenses of collecting and administering the fund
 26 shall be paid from the fund.

27 (e) Money in the fund at the end of the state's fiscal year shall
 28 remain in the fund and shall not revert to the general fund.

29 SECTION 14. IC 23-2-4-16 IS AMENDED TO READ AS
 30 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:

31 Sec. 16. (a) If a ~~home~~ **continuing care retirement community** is
 32 bankrupt and the operation of the ~~home~~ **continuing care retirement**
 33 **community** is terminated, the board of directors shall, subject to the
 34 approval of the commissioner, distribute from the guaranty association
 35 fund established in section 13 to the living residents of the ~~home~~
 36 **continuing care retirement community** an aggregate amount not to
 37 exceed one-half (1/2) of the amount in the fund at the time of
 38 disbursement. The amount each living resident is entitled to receive

1 shall be prorated, based on the total amount paid on behalf of the
 2 resident by the contracting party under the continuing care agreement.
 3 In no event may the amount paid to an individual resident under this
 4 section exceed the total amount paid on behalf of that resident under
 5 the continuing care agreement, less the total value of services received
 6 under the agreement.

7 (b) Any living resident of the ~~home~~ **continuing care retirement**
 8 **community** shall be eligible to receive distributions under subsection
 9 (a), regardless of whether any contribution to the guaranty association
 10 fund has been made on behalf of the resident.

11 (c) A resident compensated under this section assigns ~~his~~ **the**
 12 **resident's** rights under the continuing care agreement, to the extent of
 13 compensation received under this section, to the board of directors on
 14 behalf of the fund. The board of directors may require an assignment
 15 of those rights by a resident to the board, on behalf of the fund, as a
 16 condition precedent to the receipt of compensation under this section.
 17 The board of directors, on behalf of the fund, is subrogated to these
 18 rights against the assets of a bankrupt or dissolved provider. Any
 19 monies or property collected by the board of directors under this
 20 subsection shall be deposited in the fund.

21 (d) The subrogation rights of the board of directors, on behalf of the
 22 fund, have the same priority against the assets of the bankrupt or
 23 dissolved provider as those possessed by the resident under the
 24 continuing care agreement.

25 SECTION 15. IC 23-2-4-21 IS AMENDED TO READ AS
 26 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:
 27 Sec. 21. If the commissioner has reason to believe that a ~~home~~
 28 **continuing care retirement community** is insolvent, the
 29 commissioner may petition the superior or circuit court of the county
 30 in which the ~~home continuing care retirement community~~ is located,
 31 or the superior or circuit court of Marion County, for the appointment
 32 of a receiver to assume the management and possession of the ~~home~~
 33 **continuing care retirement community** and its assets.

34 SECTION 16. P.L.3-2007, SECTION 1, IS AMENDED TO READ
 35 AS FOLLOWS [EFFECTIVE OCTOBER 1, 2008 (RETROACTIVE)]:
 36 SECTION 1. (a) **As used in this SECTION, "continuing care**
 37 **retirement community" means a health care facility that:**

38 **(1) provides independent living services and health facility**

1 **services in a campus setting with common areas;**

2 **(2) holds continuing care agreements with at least twenty-five**
 3 **percent (25%) of its residents (as defined in IC 23-2-4-1);**

4 **(3) uses the money described in subdivision (2) to provide**
 5 **services to the resident before the resident may be eligible for**
 6 **Medicaid under IC 12-15; and**

7 **(4) meets the requirements of IC 23-2-4.**

8 **(b)** As used in this SECTION, "health facility" refers to a health
 9 facility that is licensed under IC 16-28 as a comprehensive care facility.

10 ~~(b)~~ **(c)** As used in this SECTION, "nursing facility" means a health
 11 facility that is certified for participation in the federal Medicaid
 12 program under Title XIX of the federal Social Security Act (42 U.S.C.
 13 1396 et seq.).

14 ~~(c)~~ **(d)** As used in this SECTION, "office" refers to the office of
 15 Medicaid policy and planning established by IC 12-8-6-1.

16 ~~(d)~~ As used in this SECTION, "total annual revenue" does not
 17 include revenue from Medicare services provided under Title XVIII of
 18 the federal Social Security Act (42 U.S.C. 1395 et seq.).

19 **(e)** Effective August 1, 2003, 2009, the office shall collect a quality
 20 assessment from each nursing health facility that has:

21 ~~(1) a Medicaid utilization rate of at least twenty-five percent~~
 22 ~~(25%); and~~

23 ~~(2) at least seven hundred thousand dollars (\$700,000) in annual~~
 24 ~~Medicaid revenue, adjusted annually by the average annual~~
 25 ~~percentage increase in Medicaid rates.~~

26 **The office shall offset the collection of the assessment for a health**
 27 **facility:**

28 **(1) against a Medicaid payment to the health facility by the**
 29 **office; or**

30 **(2) in another manner determined by the office.**

31 ~~(f) If~~ **The office shall implement the waiver approved by the**
 32 **United States Centers for Medicare and Medicaid Services determines**
 33 **not to approve payments under this SECTION using the methodology**
 34 **described in subsection (e); the office shall revise the state plan**
 35 **amendment and waiver request submitted under subsection (f) as soon**
 36 **as possible to demonstrate compliance with 42 CFR 433.68(c)(2)(ii).**
 37 **The revised state plan amendment and waiver request must provide**
 38 **that provides for the following:**

~~(1) Effective August 1, 2003, collection of a quality assessment by the office from each nursing facility.~~

~~(2) Effective August 1, 2003, collection of a quality assessment by the department of state revenue from each health facility that is not a nursing facility.~~

~~(3) An~~ an exemption from collection of a quality assessment from the following:

~~(A)~~

(1) A continuing care retirement community as follows:

(A) A nonprofit organization that is:

(i) exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code; and

(ii) registered under IC 23-2-4 before July 1, 2009.

A continuing care retirement community described in this clause is not required to meet the definition of continuing care retirement community in subsection (a).

(B) A proprietary organization that was registered with the securities commissioner as a continuing care retirement community on July 1, 2003, is not required to meet the definition of a continuing care retirement community in subsection (a).

(C) A continuing care retirement community that meets the definition set forth in subsection (a).

~~(B) A health facility that only receives revenue from Medicare services provided under 42 U.S.C. 1395 et seq.~~

~~(C)~~

~~(2) A hospital based health facility. that has less than seven hundred fifty thousand dollars (\$750,000) in total annual revenue; adjusted annually by the average annual percentage increase in Medicaid rates.~~

~~(D)~~

(3) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(g) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsections **(d) and (e)**, ~~and (f)~~, the office

1 shall revise the state plan amendment and waiver request submitted
 2 under ~~subsection (f)~~ **this SECTION** as soon as possible to demonstrate
 3 compliance with 42 CFR 433.68(e)(2)(ii) and to provide for collection
 4 of a quality assessment from health facilities effective August 1, ~~2003~~.
 5 **2009. In amending the state plan amendment and waiver request under**
 6 **this subsection, the office may modify the parameters described in**
 7 **subsection (f)(3). However, if the office determines a need to modify**
 8 **the parameters described in subsection (f)(3), the office shall modify**
 9 **the parameters in order to achieve a methodology and result as similar**
 10 **as possible to the methodology and result described in subsection (f).**
 11 **Any revision of the state plan amendment and waiver request under**
 12 **this subsection is subject to and must comply with the provisions of**
 13 **this SECTION.**

14 (h) The money collected from the quality assessment may be used
 15 only to pay the state's share of the costs for Medicaid services provided
 16 under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et
 17 seq.) as follows:

18 (1) **At the following percentages when the state's regular**
 19 **federal medical assistance percentage (FMAP) applies,**
 20 **excluding the time frame in which the adjusted FMAP is**
 21 **provided to the state by the federal American Recovery and**
 22 **Reinvestment Act of 2009:**

23 (A) Twenty percent (20%) as determined by the office.

24 ~~(2)~~ (B) Eighty percent (80%) to nursing facilities.

25 (2) **At the following percentages when the state's federal**
 26 **medical assistance percentage (FMAP) is adjusted by the**
 27 **federal American Recovery and Reinvestment Act of 2009:**

28 (A) Forty percent (40%) as determined by the office.

29 (B) Sixty percent (60%) to nursing facilities.

30 (i) After:

31 (1) the amendment to the state plan and waiver request submitted
 32 under this SECTION is approved by the United States Centers for
 33 Medicare and Medicaid Services; and

34 (2) the office calculates and begins paying enhanced
 35 reimbursement rates set forth in this SECTION;

36 the office ~~and the department of state revenue~~ shall begin the collection
 37 of the quality assessment set under this SECTION. The office ~~and the~~
 38 ~~department of state revenue shall~~ may establish a method to allow a

1 facility to enter into an agreement to pay the quality assessment
2 collected under this SECTION subject to an installment plan.

3 (j) If federal financial participation becomes unavailable to match
4 money collected from the quality assessments for the purpose of
5 enhancing reimbursement to nursing facilities for Medicaid services
6 provided under Title XIX of the federal Social Security Act (42 U.S.C.
7 1396 et seq.), the office ~~and department of state revenue~~ shall cease
8 collection of the quality assessment under this SECTION.

9 (k) To implement this SECTION, the

10 ~~(1) office shall adopt rules under IC 4-22-2. and~~

11 ~~(2) office and department of state revenue shall adopt joint rules~~
12 ~~under IC 4-22-2.~~

13 (l) Not later than ~~July 1, 2003; August 1, 2009~~, the office shall do
14 the following:

15 (1) Request the United States Department of Health and Human
16 Services under 42 CFR 433.72 to approve waivers of 42 CFR
17 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance
18 with 42 CFR 433.68(e)(2)(ii).

19 (2) Submit any state Medicaid plan amendments to the United
20 States Department of Health and Human Services that are
21 necessary to implement this SECTION.

22 (m) After approval of the waivers and state Medicaid plan
23 amendment applied for under ~~subsection (f); this SECTION~~, the office
24 ~~and the department of state revenue~~ shall implement this SECTION
25 effective ~~July 1, 2003; August 1, 2009~~.

26 (n) The select joint commission on Medicaid oversight, established
27 by IC 2-5-26-3, shall review the implementation of this SECTION. The
28 office may not make any change to the reimbursement for nursing
29 facilities unless the select joint commission on Medicaid oversight
30 recommends the reimbursement change.

31 (o) A nursing facility or a health facility may not charge the facility's
32 residents for the amount of the quality assessment that the facility pays
33 under this SECTION.

34 (p) The office may withdraw a state plan amendment **submitted**
35 under ~~subsection (e); (f); or (g)~~ **this SECTION** only if the office
36 determines that failure to withdraw the state plan amendment will
37 result in the expenditure of state funds not funded by the quality
38 assessment.

(q) If a health facility fails to pay the quality assessment under this SECTION not later than ten (10) days after the date the payment is due, the health facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(r) ~~The following shall be provided to the state department of health:~~

~~(1) The office shall report to the state department of health each nursing facility and each health facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.~~

~~(2) The department of state revenue shall report each health facility that is not a nursing facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.~~

(s) The state department of health shall do the following:

(1) Notify each nursing facility and each health facility reported under subsection (r) that the nursing facility's or health facility's license under IC 16-28 will be revoked if the quality assessment is not paid.

(2) Revoke the nursing facility's or health facility's license under IC 16-28 if the nursing facility or the health facility fails to pay the quality assessment.

(t) An action taken under subsection (s)(2) is governed by:

(1) IC 4-21.5-3-8; or

(2) IC 4-21.5-4.

(u) The office shall report the following information to the select joint commission on Medicaid oversight established by IC 2-5-26-3 at every meeting of the commission:

(1) Before the quality assessment is approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the progress in receiving approval for the quality assessment; and

(B) a summary of any discussions with the United States Centers for Medicare and Medicaid Services.

(2) After the quality assessment has been approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the collection of the quality assessment;

(B) a summary of the quality assessment payments owed by a

1 nursing facility or a health facility; and
 2 (C) any other relevant information related to the
 3 implementation of the quality assessment.

4 (v) This SECTION expires August 1, ~~2009~~ **2011**."

5 Delete page 3.

6 Page 4, delete lines 1 through 14.

7 Page 4, line 16, delete "'advisory committee" refers to the health
 8 policy" and insert **"committee" refers to the Medicaid managed
 9 care quality strategy committee created by this SECTION.**

10 **(b) the Medicaid managed care quality strategy committee is**
 11 **created to provide information on policy issues concerning**
 12 **Medicaid. The committee shall study issues related to the**
 13 **following:**

14 **(1) Emergency room utilization.**

15 **(2) Prior authorization.**

16 **(3) Standardization of procedures, forms, and service**
 17 **descriptions.**

18 **(4) Effectiveness and quality of care.**

19 **(c) The members of the committee shall include at least one (1)**
 20 **individual representing each of the following:**

21 **(1) Medicaid providers.**

22 **(2) Public hospitals.**

23 **(3) Medicaid managed care organizations.**

24 **(4) Mental health professions.**

25 **(5) The office of Medicaid policy and planning, who shall act**
 26 **as chairperson of the committee.**

27 **(6) Other state agencies.**

28 **The governor shall appoint the committee members. The**
 29 **committee may not consist of more than seven (7) members.**

30 **(d) The office of the secretary of family and social services shall**
 31 **staff the committee.**

32 **(e) The affirmative votes of a majority of the members are**
 33 **required for the committee to take make recommendations.**

34 **(f) Before October 1, 2009, the committee shall report to the**
 35 **select joint commission on Medicaid oversight established by**
 36 **IC 2-5-26-3 concerning the committee's recommendations.**

37 **(g) This SECTION expires December 31, 2009."**

38 Page 4, delete lines 17 through 42.

- 1 Page 5, delete lines 1 through 41.
- 2 Renumber all SECTIONS consecutively.
(Reference is to HB 1572 as printed February 20, 2009.)

and when so amended that said bill do pass.

Committee Vote: Yeas 7, Nays 0.

Miller

Chairperson